Reaching the Poor through Demand Subsidies: The Colombian Health Reform

A Discussion Paper

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Inter-American Development Bank
Washington, D.C.
June, 2000

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Preface

The following are reflections from a seminar that took place in Barranquilla, Colombia, November 15-19, 1999, in which presentations were made by Colombian academics, mayors, hospital managers, regulators, EPS Directors, and newly insured individuals. This is not meant to be a systematic evaluation of the reform, but rather an outsider's view from an intense week of interviews, presentations, and local visits.

What is the Essence of the Colombian Health Reform?

The Colombian Health Reform is seeking to equalize access to health services for the poor by giving them insurance that can purchase care from public or private providers. This leveling was strikingly presented to us by a young woman, affiliated with SolCaribe in Barranquilla, who has had two operations for a malignant tumor in her brain. She would not have been able to afford the operations without the current insurance scheme. Furthermore, when the public hospital was on strike at a time when she needed the operation, the insurer arranged to have her treated at a private clinic. I cannot imagine a more dramatic demonstration of what the Colombian Reform has achieved in only two years since the subsidized regime was implemented.

This is not an isolated case. When the public Hospital Universitario de Barranquilla went on strike in 1998 and 1999 for more than 6 months, 85% of the services it normally would have provided were taken care of by other providers in the local network – whether private clinics and practices, or primary and secondary public centers. In even more general terms, national health insurance increased coverage by some 5 million beneficiaries almost immediately, largely because of making family members of payroll contributors eligible. However, after 3 years, the major increase in coverage has occurred in the first two quintiles of the population. In 1993, approximately 8% of the poorest two quintiles had insurance compared to approximately 30% of those in higher income categories. In 1998, these figures had increased to 53% and 67%, respectively. About 8 million Colombians who had little or no access to health insurance, particularly for high cost treatments, are now covered.[1].

How does it work?

With Ley 10 in 1990, Colombia took a step being followed by many countries in Latin America to decentralize most public services to the Department or Municipal level. The aim of this decentralization had little to do with improving the equity or efficiency of health services, *per se*. Rather it responded to the national political process of devolving responsibilities.

With Ley 100 in 1993, however, Colombia took a step that is unique in Latin America, not because it created demand subsidies for the poor, but because it did so in a national program that made demand for services the prime mechanism for allocating resources in the health system as a whole.

Ley 100 created a national universal health insurance system with two forms of affiliation. For those with sufficient income, a payroll tax of 12% is collected and a comprehensive insurance plan (Plan Obligatorio de Salud) is provided (*Regimen Contributivo*). For those with insufficient income, the government (through various sources described below) purchases the insurance (*Regimen Subsidiado*).[2] In both cases, the affiliated individual chooses a health insurance company (Entidad Promotora de Salud – EPS) whose ownership may be public, private or mixed, and which may be run for profit or as a non-profit. The EPS, in turn, contracts health services with a network of service providers (Instituciones Prestadores de Servicios de Salud – IPS). These IPS may also be of any form of ownership, public, for profit or non-profit.

From the perspective of the individual, this is as far as it goes. But behind the scenes, a lot more is going on. First, the government sets the premium that will be paid to each EPS for each individual called the Unidad de Pago por Capitación (UPC) with a risk adjustment by age and sex.[3] This premium is about $140 per person per year.[4] Therefore, the EPS has the same incentive to sign up a poor person as a rich one.[5] Second, the government has an explicit mechanism for channeling resources from individual whose 12% payroll contributions are greater than the premium toward those whose contribution are less. It is a fund (Fondo de Solidaridad y Garantia – FOSYGA) which receives the "excess" contributions from the EPS and reapportions funds toward EPS's whose contributions fall short of the UPC. Third, a portion of the payroll tax (1% of the payroll) is channeled by FOSYGA into paying for those insured under the *Regimen Subsidiado*.

How do you get there?

Thusfar, I've described the main financial architecture and institutions, but how do you get from the typical segmented Latin American system to this new one? Several changes had to occur.

First, public institutions had to convert themselves into autonomous entities. The Instituto de Seguro Social was constituted as an EPS, and has to compete with other EPS's for affiliates. Public hospitals and health centers converted themselves to "Empresas Sociales del Estado" (ESE) with the ability to charge EPS's for services provided to those with insurance. Second, the government gradually reduced the budgetary support for the ESE that was based on installed capacity and forced them to rely increasingly on the income from serving people with insurance.[6] Third, the government had to identify who would receive the *Regimen Subsidiado*. It did so with a new instrument, the Sistema de Identificacion de Beneficiarios de Programas Sociales (SISBEN) which uses surveys and indicators to rank individuals, but which has decentralized implementation to municipalities. Fourth, the government had to find ways to finance the people covered under the *Regimen Subsidiado*. This is where Ley 100 – the health reform – intersects with Ley 10 – decentralization and Ley 60 – fiscal decentralization.

The money to finance the *Regimen Subsidiado* comes from several basic sources: direct payments from the national budget; FOSYGA; automatic transfers from the national treasury to the Departamentos (Situado Fiscal based on Ley 60), a portion of which are earmarked for health services; and other funds available to Departamentos and Municipalities. The main sources currently are FOSYGA and the Situado Fiscal.

Decentralization, Helps, Hurts, or Just Confuses Health Reform?

In many ways, the decentralization in Colombia is not only unnecessary for the health reform, it is actually problematic. The health reform could essentially function with direct payments from FOSYGA and the national treasury to the insurance companies (EPS) that have enrolled beneficiaries. By transferring funds to the Departamentos and then from there to the municipalities and finally to the EPS, more transaction costs arise and opportunities for diverting funds or misallocation can occur. Geographic inequities arise between eligible beneficiaries who live in Departamentos or Municipalities that are responsible and put more resources into the *Regimen Subsidiado* than those who live under less responsible local governments. Mayors have also been accused of politically manipulating the process of identifying beneficiaries. Finally, the municipalities are now responsible for the public hospitals and health centers, and may try to protect these public institutions from competition – at the cost of restricting the poor to public institutions that have frequently provided poorer quality care.

In other ways, the decentralization has been essential to the success of the reform. First, it is not clear whether the national government would ever have provided sufficient resources to the *Regimen Subsidiado*. Because of the combination of transferring resources to the subnational authorities with earmarking *and* transferring the responsibility for contracting the EPS to cover beneficiaries, a huge source of funding was effectively assured for the program. Second, the decentralization has generated a class of local politicians who can more directly benefit from the program's success (by providing this "free" health insurance to eligible constituents), and who have an interest in holding the local EPS's accountable for providing services.

In the other direction, the health reform (Ley 100) may have been critical to some of the successes of decentralization. Many municipalities are simply not equipped institutionally or in staffing to administer health centers and hospitals. The creation of independent insurers (EPS) and providers (IPS) put technical offices – medical, financial and managerial – in the service of the municipalities who then contracted with them.

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Aren't there too many intermediaries?

We heard from four mayors who argued that the insurers were unnecessary – claiming that it would reduce costs and problems if they could contract directly with the IPS to provide services to beneficiaries in their municipalities. We also heard from several insurers who argued that the mayors were unnecessary – claiming that it would reduce costs and problems if they could receive payment of premiums directly from the national government or FOSYGA. The mayors and managers that we heard from were not a representative sample. Rather, they were the ones who acted responsibly – and complained about their respective counterparts who were less responsible. One conclusion to take from this would be to "put control in the hands of the group that is going to be responsible". Clearly, we cannot identify this *ex ante* from the national level. Given that the world is imperfect, and our limited ability to screen who will function best, the current setup in which mayors contract with insurers may be quite good. In cases where one or the other fails in its responsibility, at least there is someone who has an interest in calling attention to the fact, and to holding them accountable. This doesn't mean the process is pleasant, or rapid, but it does mean that the system has built-in mechanisms for correcting itself that didn't exist in the previous system.

Is the System Financially Viable?

This was perhaps the biggest surprise for me. I was sure that the provision of a comprehensive package for all Colombians would be out of the country's financial reach. I also expected that the public hospitals and health clinics were too inefficient, too constrained, and too overstaffed to be able to survive under the new system. In both cases, I was wrong.

Take the case of one ESE, Hospital de Campo de la Cruz in the Departamento of Atlantico. This ESE runs a primary level hospital in a small municipality (about 30,000 residents) a few hours from Barranquilla. It has 67 staff members and a budget of about US$1.2 million / year. There are 25,000 people in the municipality identified as eligible for the *Regimen Subsidiado*, but there was only enough money to cover 5,000. The remaining 20,000 eligible beneficiaries receive services from the ESE as "*vinculados*", i.e. uninsured individuals for whom services continue to be financed by the government's infusion of funds for budget support. The ESE receives 50% of its funds in the form of direct budget support and 50% of its funds from income (capitated payments and fee for service paid by the EPS insurers). The hospital director said that the ESE is currently financially viable if it received all its payments on time (and this is only two years after functioning under the new scheme).

What does this mean? First, it means that the US$1.2 million budget is fully sufficient to cover services for the population of this municipality – whether "covered" by the new subsidy regime or not – since the so-called "*vinculados*" are still being served. Second, it means that the UPC is more generous than it needs to be. The average cost of serving the 25,000 eligible beneficiaries is approximately $50 per person per year; while the UPC for the subsidized regime is currently $80! Third, the constraint on the public institutions with respect to overstaffing was resolved in this particular ESE not by firing personnel (which they could not do) but by increasing the number of services provided by the same staff (i.e. increased productivity). By increasing the number of services provided, in a scheme which finances them based on output, they were able to maintain employment by increasing revenues. The only problem faced by this particular hospital director with respect to staffing was that he would prefer to change some of the composition of his staffing, reducing the number of auxiliary nurses so that he could contract better support in managing the hospital's finances and accounts.

Another surprise was the affordability of insurance for low probability high cost interventions. SolCaribe, an ESS in Barranquilla, has only 7,000 affiliates which makes it far too small to self-insure for high cost treatments. They purchase reinsurance with a Colombian firm for about $4/member/year. This insurance allows SolCaribe to limit their total exposure per event to $5,000. In the case of the woman with a malignant brain tumor, all costs in excess of $5,000 are being covered by the reinsurer.

This argument about the financial viability of the system is also supported by a national study (Fundacion Corona) that demonstrated the current amount of public funding is more than sufficient to cover all Colombians under a pure insurance scheme – that is without the direct budget support that continues to flow to public institutions. In fact, leaving the scheme in its current 50/50 situation may be responsible for raising the total national cost of the health system – which has grown from about 7% of GDP to over 10% of GDP in only the last three years. By converting fully to the insurance demand subsidy, expenditures on health services would be more transparent and related directly to the UPC and the number of affiliated individuals. In the current system, the continued flow of supply-side money to public hospitals and health centers, at the same time that they can raise their own revenues from the sale of services, creates a non-transparent transfer of resources.

So is Everything Just Wonderful?

No, of course not. The system is going through a number of growing pains and difficulties, some of which might have been avoidable, others not.

First, Colombia has been in an economic and financial crisis since the reform was implemented. This has reduced the number of individuals contributing through payroll taxes (unemployment has risen from 12% to over 20%) and, by implication, paying taxes that are necessary to support the *Regimen Subsidiado*. The financial and banking crisis has also created liquidity problems that make it difficult to raise capital for these new endeavors and to assure a smooth flow of payments from one agent to another.

Second, many of the new agents have not fulfilled their obligations. There are mayors who are using resources earmarked for the *Regimen Subsidiado* for other purposes (sometimes legitimate, sometimes not). This generates large balances of accounts receivable for the EPS who may then be unable to pay the IPS, which is then unable to continue serving its population. There are also EPS that are denying payments to IPS, delaying payment, or simply not paying the IPS. There are also IPS that were created to receive payments but which did not really have an adequate network to provide the contracted services. The firm, which was hired to run FOSYGA, has also delayed transfers because it gets to keep the interest on the balance in the FOSYGA account.

This noncompliance may be partially due to agents being unaware of their responsibilities – which would indicate the importance of training, dissemination, marketing and publicity regarding all the agents' rights and responsibilities. But the continued noncompliance is also evidence of inadequate regulation and control. These issues were clarified by the Superintendent of Health, who described a series of obstacles to effective regulation:

- It has been difficult to verify the number of people affiliated with different EPS's due to the lack of an adequate information system. It is only now that the country is beginning to develop *a "Registro Unico de Aportantes"* that should make it possible to determine who is covered by whom, eliminate duplicate affiliations, and update insurance rolls for deaths, births and moves.
- The Superintendancy has been underfunded. The current Superintendent believes that it can operate with fewer than its current number of 230 employees by contracting audits, inspections and reviews with private firms. But this still requires adequate funds. This year, the government approved a fee to be paid by those who are regulated by the Superintendancy.
- Complexity of norms and reporting requirements make compliance difficult and control impossible. The government has continued to pass new regulations that confuse

regulated institutions. The reporting requirements are extensive and complex making it difficult to verify the quality of reported data and to use it. The Superintendent recommended starting with much simpler, basic reporting requirements, to assure a few key functions, rather than laying on top of the system the data related to goals that will only be reached a decade down the road.

- A responsive network of law enforcement and an effective judicial system would also be greatly helpful. In those cases where the Superintendancy has detected and reported irregularities, only rarely has the responsible law enforcement agency taken action.

What Went Right? What Went Wrong?

One of the main things that "went right" was the passage of a law and design for the reform that created *pressure for supporting change*. Bringing new financial resources into the system, but under a new payment mechanism, generated support from new actors. Autonomy for public providers gave them both, the ability to respond to these new mechanisms and the incentive to do something with it (because they faced competition). Allowing private and non-profit enterprises to enter the system leveraged expertise in business management, community participation, outreach, and marketing. Assuring a multiplicity of providers made it more likely that the country would find some organizational arrangements that would succeed.

Many things also "went wrong". Perhaps the greatest problem with the reform was that soon after it was approved in its legal character, the government changed and the new government was not committed to the reform. This might have been addressed through a stronger focus on "change management". The reformers might have better assured continuity and smooth implementation if the incoming government (and society as a whole) better understood the underlying logic and concepts of the new reform. This could have been done through teaching, dissemination, "marketing", and training. (On the other hand, one can imagine that their hands were full with many other critical things at that time).

It is clear that the regulation, auditing, and control functions were not developed strongly and quickly enough. In particular, a reform that relies heavily on changing the flow of financial resources need timely monitoring of financial flows and rapid response to nonpayment or diversion of funds.

Fundamental public health interventions (particularly vaccinations) may have suffered during the last few years because of overlapping responsibilities in this area. Municipalities continued to be responsible for the PAB (Programa de Atención Básica) while insurers (EPS) were expected to cover similar services. This overlap is clearly not functional and would need to be worked out in any future efforts like this.

It is interesting that support for creation of nonprofit health insurers (Empresas Solidarias de Salud – ESS) may have been useful politically, may be good in particular instances, but doesn't seem to have been critical to the reform. After initially favoring the creation of these institutions through reduced capital requirements, the government is now applying the same standards for financial solvency and raising the minimum number of members necessary to establish an ESS.

It is also worth noting that the explicit mechanism for solidarity, FOSYGA, is only one possible mechanism for financing a universal insurance scheme of this nature. The government could just as easily, perhaps more easily, have financed the *Regimen Subsidiado*

directly out of general revenues. Alternatively, the entire scheme could be financed out of general revenues – relying on the progressivity of general taxation to assure solidarity. There are no administrative advantages to FOSYGA, but there may be political advantages – both for generating support for the system by demonstrating an explicit solidarity mechanism and by creating an earmarked source of funding for the new scheme.

Lessons

- Using demand subsidies to provide health insurance for the poor works.
- Public entities (hospitals, health centers) can compete effectively with the private sector if they are given autonomy.
- There may easily be enough money in the health system to create universal insurance coverage if those funds are shifted from supporting supply to financing demand.
- Watch out for public health functions. It is probably better to retain responsibility for basic public health functions (vaccinations, nutritional promotion, vector control) in the public sector rather than with the new insurance entities, at least until coverage is effective and universal. Municipal public health offices can be used to fill this public health function, or the services can be contracted directly by the Ministry with public or private non-entities. Either way, responsibilities should be clear and some form of central coordination is required.
- Don't underestimate the need for training, marketing, auditing, and control during implementation.
- Don't overestimate the value of laws and regulations in implementing change. They are only the beginning.
- Consider insurance packages that include only most basic cost effective care along with reinsurance for high cost treatments.
- The cost of reinsurance for high-cost, low-probability events is quite reasonable for a country like Colombia and can be included in a universal insurance package.
- Don't overload information systems with too much data. Be parsimonious but effective with the kind of data that is collected, and make sure that information is analyzed and acted upon in a timely fashion.

Endnotes

[1] Sánchez, F. and Nuñez, J. "La Ley 100/93 Sí llegó a las personas de menores ingresos", Revista Vía Salud, tercer trimestre de 1999.
[2] During a transition period, scheduled to end in 2001, the *Regimen Subsidiado* purchases a somewhat less comprehensive plan. The POS-S (plan for the *Regimen Subsidiado*) covers basic primary services (e.g. maternal and infant care), urgent care and high cost care; while the POS covers intermediate cost services as well (e.g. physical therapy). The difference was made for cost reasons.
[3] Note, that originally I assumed that the risk adjustment had to be as good as possible to assure that firms would be paid adequately. This would be extremely difficult because we have very few objective indicators to be able to measure and predict future illnesses (other than past patient history). However, I realized that the main purpose of the risk-adjustment is *not* to compensate the EPS adequately. That only needs to be done on average. The real purpose is to correct for the objective factors *that the EPS might use for adverse selection*! Therefore, age and sex adjustments may be quite sufficient.
[4] About $80 per year in the *Regimen Subsidiado* because it covers fewer services. Presumably as the subsidized package moves toward parity with the package under the *Regimen Contributivo*, the unit cost will also have to converge.
[5] Although the price is equal, the expected cost of caring for a poor person may be higher due to the expectation that they are exposed to conditions that are less healthy and have fewer resources to protect their health. Nevertheless, the equalization of premiums goes a long way to levelling the EPS's interest in getting members from all income classes.
[6] Currently, the government has frozen this transition at 50% budget support and 50% revenues from providing services to insured individuals.